# Shape  Description automatically generated with low confidencecid:image001.gif@01C8CB13.92258A10 **A close up of a sign  Description automatically generated**

**Alder Hey Children’s**

**NHS Foundation Trust**

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## SERVICE REQUEST FOR

## CHILDREN’S TARGETED / SPECIALIST SERVICES

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| --- | --- | --- | --- |
| Title:  |  | Address:  |  |
| Surname:   |  |
| Forename 1:  |  |
| Forename 2:  |  | Town |  |
| Pref. Forename:  |  | County: |  |
| Birth Date:  |  | Postcode:  |  |
| Gender:  |  | Age:  |  |
| Home Tel No:  |  | Parent/CarerMobile No:  |  |
| NHS Number:  |  | Hospital No: |  |
| Name of Parent / Guardian: |  | Parent/Carer email address: |
| Address of parent/guardian if different from child: |  | GP Name and Address: |  |
| Religion:  |  | Ethnicity:  |  |
| Interpreter Needed?:  |  | Language as spoken: *(only to be entered when an interpreter is required)* |  |
| Professional Involved in Care: |  | Returner to Service:  | Yes / No? |
| Disability: |  | Date previously known to service: |  |
| Health Visitor/School name and contact details: |   |
| Nursery/school contact details: |  |
| Does the child have any of the following (if so please attach): | Early Help Assessment:    Yes / NoEducation Health Care Plan: Yes / NoChild Protection Plan: Yes / NoCourt Order: Yes / No |
| **Details of child’s difficulties and how they are impacting on the child at home, for example at school/nursery and in functional / social situations):**Which services do you require? Please refer to CDT leaflet which details services available.How will services be able to help? What difference will this make to the child and their family? |
| **Health Practitioners: Have you requested Hearing and/or Vision Screening?****Date requested:** |
| **Use this space to include any additional medical information/diagnosis, special requirements or significant information:**  |

|  |
| --- |
| Does your child require assessment regarding **feeding and swallowing**? YES/NO If YES – please complete the following questions a) Is your child given food completely orally? YES/NO b) Has the child had a videofluroscopy? YES/NO c) Are there any medical concerns related to eating/drinking? YES/NOPlease specify …………………………………………………………………………………………………………………………………………………………………………………………………………..……………………………………………………………………………………………………………… |

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| **What strategies are you currently using to support the child?****Details of other services or support the child, family and school are currently accessing. Please include if child is already known to CDT:** |
| Other Agencies involved: (please list)  |
| **Name** | **Profession** | **Address** | **Tel No.** |
|  |  |  |  |
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|  |  |  |  |
| **NB** - CDT will not accept this referral unless we have parental consent either verbally or written. If verbal consent gained this must be typed in in parental signature box with the date of consent **Parental Consent**I consent to providing Children’s Targeted/Specialist Services with the information on this form and understand it will be discussed by appropriate agencies. My information will be stored securely and will not be shared without my consent unless the law and data protection rules allow it.I understand that my information will be stored safely as per the General Data Protection Regulation.If you would like more detail about how your information is processed, please ask your referrer, or see our website at <https://www.knowsley.gov.uk/residents/early-years-support/knowsley-early-years-service> |
| Parental Signature:  |  | Parent name: |  |
| Name of Referrer: |  | Designation of Referrer: |  |
| **Please supply email address of Referrer for outcomes of CDT and other correspondence****EMAIL:** |
| Postal Address of Referrer: |  | Tel No: |  |
| Signature of Referrer: |  | Date of referral: |  |

If relevant, please tick if you have included the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Early Help AssessmentMinutes of Team Around Family Meetings (most recent) |  | Personal Pupil Plan or / Play Plans including Evaluations |  |
| Seedling’s programme **\*****\*Mandatory if requesting Occupational Therapy support around sensory issues** |  | Audiology results |  |
| Paediatrician Assessment report/s or reports from any other involved Agencies |  |  |  |
| Health Visitor developmental check (Ages & Stages Questionnaire) |  |  |  |
| WELLCOMM screening \*\***\*\* Mandatory if making a referral to Speech & Language Therapy Service** **NB** - Out of Borough settings need to provide their own screenings assessments or a communication support plan which focuses on the child’s needs as an alternative to WELLCOMM screening  |  |  |  |

**Referrals requesting either Paediatric Physiotherapy or Occupational Therapy only should be sent direct via email to:** **mcn-tr.paediatric-therapy-service@nhs.net**

**All other Multi Agency Service Requests should be fully completed and emailed to** **childdevelopmentteam@knowsley.gov.uk**